Declination of Influenza Vaccination

My employer or affiliated health facility,	_, has
recommended that I receive influenza vaccination in order to protect the	patients I
serve.	

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other health care workers to prevent influenza disease and its complications, including death.
- If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus can spread influenza infection to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infection change almost every year which is why a different influenza vaccine is recommended each year.
- I cannot get the influenza disease from the influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:
 - ▼ Patients in this healthcare setting
 - ▼ My coworkers
 - ▼ My family
 - ▼ My community

I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.

I have read and fully understand the information on this declination form.

Signature:	Date:
Name (print):	
Department:	